

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  CELINA HEALTH AND REHABILITATION CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  During the annual licensure survey conducted on December 1, 2011, at Celina Health and Rehabilitation Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Paul B. Borne*

TITLE

*Administrator*

(X6) DATE

12/14/11

STATE FORM

5899

QSDD11

If continuation sheet 1 of 1

DEC 16 2011